

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2807AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2008
NAME OF PROVIDER OR SUPPLIER RUNAMAR HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7907 MOUNTAIN MAN WAY LAS VEGAS, NV 89113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on 11/04/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, three Category I residents and five Category II residents and/or persons with mental illnesses. The census at the time of the survey was seven. Seven resident files were reviewed and five employee files were reviewed. The following regulatory deficiencies were identified:	Y 000		
Y 072 SS=D	449.196(3) Qualications of Caregiver-Med re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every	Y 072		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2807AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2008
NAME OF PROVIDER OR SUPPLIER RUNAMAR HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7907 MOUNTAIN MAN WAY LAS VEGAS, NV 89113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 072	Continued From page 1 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 11/4/08, the facility failed to document medication management training for 1 of 5 employees (#3). Findings include: The file for Employee #3 lacked documentation of medication management training. Severity: 2 Scope: 1	Y 072		
Y 101 SS=B	449.200(1)(b) Personnel File - date of hire NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (b) The date on which the employee began his employment at the residential facility. This Regulation is not met as evidenced by: Based on record review on 11/4/08, the facility failed to document hire dates for 2 of 5	Y 101		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2807AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2008
NAME OF PROVIDER OR SUPPLIER RUNAMAR HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7907 MOUNTAIN MAN WAY LAS VEGAS, NV 89113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 101	Continued From page 2 employees (#3 and #5). Findings include: The files for Employee #3 and #4 lacked hire dates. Severity: 1 Scope: 2	Y 101		
Y 103 SS=D	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Based on record review on 11/4/08, the facility failed to document a pre-employment physical for 1 of 5 employees (#4). Findings include: The file for Employee #4 (hired 10/01/02) lacked documentation indicating the employee was in a state of good health, was free from active tuberculosis, and any other communicable diseases. Severity: 2 Scope: 1	Y 103		
Y 104 SS=B	449.200(1)(e) Personnel File - References	Y 104		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2807AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2008
NAME OF PROVIDER OR SUPPLIER RUNAMAR HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7907 MOUNTAIN MAN WAY LAS VEGAS, NV 89113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 104	Continued From page 3 NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (e) Evidence that the references supplied by the employee were checked by the residential facility. This Regulation is not met as evidenced by: Based on record review on 11/4/08, the facility failed to document reference checks for 2 of 5 employees (#3 and #5). Findings include: The files for Employee #3 and #4 lacked reference checks. Severity: 1 Scope: 2	Y 104		
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.	Y 859		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2807AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2008
NAME OF PROVIDER OR SUPPLIER RUNAMAR HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7907 MOUNTAIN MAN WAY LAS VEGAS, NV 89113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 859	Continued From page 4 This Regulation is not met as evidenced by: Based on record review on 11/4/08, the facility failed to document an annual physical for 2 of 5 residents (#4 and #5). Findings include: Resident #4 was admitted to the facility on 5/3/08. The resident's file lacked documentation of an initial physical exam. Resident #5 was admitted to the facility on 8/28/07. The resident's file lacked an annual physical exam for 2008. Severity: 2 Scope: 2	Y 859		
Y 877 SS=D	449.2742(5) OTC medications & Dietary Supplements NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medication and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744.	Y 877		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2807AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/04/2008
NAME OF PROVIDER OR SUPPLIER RUNAMAR HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7907 MOUNTAIN MAN WAY LAS VEGAS, NV 89113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 877	Continued From page 5 This Regulation is not met as evidenced by: Based on observation and record review on 11/4/08, the facility failed to administer over-the-counter medication with a physician's order for 1 of 7 residents (#6). Findings include: On 11/04/08, a bottle of Aleve was observed with Resident #6's medications. Resident #6's November 2008 medication administration record indicated one 220 mg capsule of Aleve could be administered as needed every 8-12 hours. Resident #6's file lacked a physician's order to prescribe Aleve. Severity: 2 Scope: 1	Y 877			
Y 936 SS=D	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 11/4/08, the facility failed to ensure 1 of 7 residents received	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2807AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/04/2008
NAME OF PROVIDER OR SUPPLIER RUNAMAR HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7907 MOUNTAIN MAN WAY LAS VEGAS, NV 89113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 936	<p>Continued From page 6</p> <p>tuberculosis (TB) testing (#5).</p> <p>Findings include:</p> <p>The file for Resident #5 lacked documentation of an initial two-step TB test result since being admitted to the facility on 8/27/08. The file contained a one-step test result dated 8/17/07, but lacked a second-step TB test. This resident needs a two-step TB skin test.</p> <p>Severity: 2 Scope: 1</p>	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.